

People normally protect themselves from overwhelming psychic pain by the familiar mechanisms of becoming numb at the receipt of totally unexpected catastrophic news, and later by denial and other defences. Thus they pace the entry of this knowledge into awareness, keeping it at a level where they can just cope. Interference with this natural pacing, by unwittingly confronting a patient with information about himself that he is not ready to assimilate, can precipitate undue distress. I have seen this happen when a patient has been upset by an apparently completely tactful interview, by a medical student or trainee (or myself, particularly when I was beginning this work). Experience and sensitivity to patients' cues gradually enable an interviewer to learn how to avoid this on most occasions. But the average patient has a wish to know, as well as a wish to deny, and the interview may be the moment when he does find out more, and is temporarily thrown by what he discovers. Recognizing that this has happened, and providing the necessary support, must be part of the equipment of the interviewer. In practice, the interviewer usually leaves the bedside thinking that all has gone well, but a nurse finds the patient in tears an hour or two later. He may not even be able to pinpoint the part of the interview that upset him, but he is likely to refuse to see the interviewer again. Understanding what has happened, and helping the patient over this mini-crisis, does require a certain amount of skill, either on the part of the interviewer, if he can get back into the dialogue, or someone else. Appropriately used, the situation can further the patient's adjustment, and he may even be grateful for it later. Badly handled, it leaves an upset, angry patient, and a residue of hostility towards the interviewer, which is usually picked up very quickly by other staff with consequences which could make it harder for the research to continue. I guess the 'Division of Psychiatry' to which your correspondent refers has just this sort of thing in mind when they advocated using a psychiatrist.

But just using a psychiatrist would not necessarily provide an adequate safeguard. Some of us who work regularly in hospices met together recently and we recognized that our basic psychiatric training did not equip us sufficiently to handle the special problems of dying patients. We know that some people without formal training do it very well, because they are sensitive and know intuitively how to respond, as a result of their own life experience. So I sympathize with your correspondent when he asks if dying is the province of the psychiatrist. It is, but only in as much as any other stressful life event which can precipitate psychiatric illness. Even then the psychiatrist is only in a better position than other people to help if he knows how to use his training to the best advantage of the patient. Not all of us do.

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DEAR SIR

Dr Verma (*Bulletin*, July 1981), asks several questions

concerning the role of psychiatrists in the care of the dying. These very issues were recently the subject of a document produced by eight psychiatrists from various countries who took part in the First International Hospice Conference at St Christopher's Hospice during 1980. The resulting document is printed below, and seems to provide a good answer to your correspondent's questions.

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The Role of the Psychiatrist in the Care of the Dying

1. Hospice and other forms of care of the dying require us to understand the complex inter-relationships of the biological, psychological, social and spiritual needs of patients, families and care-givers.
2. Each group that offers this care must develop its own approaches and must choose the most appropriate staff to meet all of these needs.
3. While recognizing the skills and interests possessed by members of other disciplines who provide counselling and psychosocial support, it is the opinion of the undersigned that the psychiatrist, by reason of training and experience in both medical and behavioural fields, has special skills of value to patients, families and the care-giving team. These include:
 - (a) Assisting others of the treatment team in the diagnosis and treatment of the organic and functional psychiatric disorders that may accompany the last stages of life of some people (and reassuring others of the normality of their responses to stress).
 - (b) Working with others of the treatment team to advise on the use of medication and other forms of treatment that may affect behaviour, mood and cognition.
 - (c) It is the combination of medical and psychodynamic skills which place the psychiatrist in a position to understand and assist with the psychological aspects of life threatening disease for patients and family.
4. We affirm that:
 - (a) Dying is not psychiatric illness.
 - (b) The psychiatrists should be a member of the team rather than detached consultants to whom people are passed for treatment.
 - (c) Psychiatrists must be open to learn from, as well as to instruct, and work with other members of the team of all disciplines.
 - (d) Psychiatrists should not have sole responsibility for staff support although their special skills in the understanding of psychosocial issues will often enable him to make a useful contribution in this field.
5. We recognize that, at the present time, psychiatrists who have the necessary skills are not always available to those who are pioneering the Hospices and similar units which are developing in so many parts of the world. We regret this fact and recommend that every effort be made to recruit suitable psychiatrists in order to rectify this unsatisfactory situation.

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OLSEN; COLIN MURRAY PARKES AND STEPHEN SHANFIELD.

[See also Dr Stedeford's account of the conference, p. 189.]